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Testimony of Sheldon Toubman Before the Insurance and Real Estate Committee in Opposition to HB 5485

I am a staff attorney with New Haven Legal Assistance Association and I am testifying in opposition to HB 5485, which, in Section 3, would specifically deprive Connecticut, its taxpayers and its low-income residents between 133 and 200% of the federal poverty level of the benefits of a Basic Health Program ("BHP"), a critical option for all states under the Patient Protection and Affordable Care Act ("PPACA").

Without a BHP, individuals over 133% of the federal poverty level would be required to get insurance from a private risk-based insurer through the Health Insurance Exchange. Unfortunately, all estimates indicate that, for individuals between this income level and 200% of the federal poverty level, even with the substantial federal tax subsidies, this coverage will be unaffordable for many. For example, even the most conservative estimate by the state's consultant, Mercer, Inc., found that individuals at the bottom of this income band, 133%, would have to pay at least $100 per month for coverage, when, for the current HUSKY A Medicaid program, there is no cost-sharing even at 185% of poverty-- precisely because of the unaffordability of such costs at these income levels.

Beyond that, without a BHP, individuals in this band would be subject to substantial disruptions as their incomes went above and below 133% of the poverty level, and children and parents in families would find that they are in completely different plans. What a broad coalition of advocates and providers are seeking is an efficient, unitary system for all non-elderly individuals up to 200% of the poverty level, based on the Medicaid program, with the same benefits, cost-sharing protections, consumer protections and provider network for BHP enrollees as are available under that program. This will make access to health care seamless for individuals who go above and below the 133% guideline and among individuals in the same family.

A BHP, as provided under HB 5450 before the Human Services Committee, will provide alternative insurance which is affordable for all of these individuals, and which is as similar to Medicaid as possible. The substantial benefits of a Medicaid-like BHP, particularly when administered along-side Medicaid, with low overhead, efficiencies of scale, and joint

administration through the same non-risk administrative services organization (ASO), with the same provider network, cannot be overstated.

In its January 19, 2012 report to the Board of the Health Insurance Exchange, Mercer found that such a Medicaid-like system with the same benefits and cost-sharing protections as Medicaid also is financially feasible in Connecticut, without any need for additional state dollars beyond what it will be receiving from the federal government (95% of saved tax subsidy payments which would otherwise be made for these individuals in the health insurance exchange). Mercer concluded that "**under any scenario** based on the estimated subsidy and costs modeled in this analysis, the result is that **it would be financially feasible for Connecticut to offer a BHP option at Medicaid provider reimbursement levels with no costs to the State.**" (page 188)(emphasis added).

Recognizing that seemingly modest cost-sharing still would cause many at the 133 to 200% of poverty income levels to opt not to participate in the BHP, Mercer modeled cost-sharing to match Medicaid in Connecticut, i.e., no premiums and no cost-sharing:

> **This [no cost-sharing] Medicaid scenario provides the *best advantage to this low-income population, which would also have the best chance of maximizing enrollment.*** (page 187)(emphasis added).

Even for this scenario, Mercer concluded that it would cost 7% less for Connecticut to run a BHP program compared to how much it would be paid by the federal government for creating the BHP (page 187). So, based on Mercer's conservative analysis, there will be enough money available for Connecticut to provide Medicaid-like benefits under a BHP without any need for additional state funding.

In reaching its conclusions about a 7% cushion, however, Mercer **substantially underestimated** the savings from a BHP over (95% of) federal subsidies for enrollment with the exchange, in three important ways.

First, it assumed that the administrative cost for providing Medicaid-like services to the BHP group would be "15% (including profit, risk, contingency loading)" (pages 184, 185). But the total administrative costs for administering Medicaid on a non-risk basis are more like **8%**, not 15%.

Second, placing all Medicaid and BHP enrollees under one efficient administrative system, presumably through all the same ASOs, will avoid the administrative costs of someone around 133% of poverty churning between different systems and different sets of providers as their income fluctuates. Beyond this, just having everyone in one system will bring economies of scale, further driving down administrative costs.

Third, in moving to the ASO model for the Medicaid/HUSKY B population in January of this year, the Malloy Administration made clear that it assumes substantial savings from finally coordinating health care in a way that the risk-based MCOs always promised but rarely delivered on. Specifically, through the adoption of patient-centered medical homes which are paid modestly to coordinate all health care for their patients, a lot of unnecessary diagnosis and treatment can be avoided.

For all of these reasons, the 7% margin for the state taking on a BHP with no cost-sharing for BHP enrollees identified by Mercer is quite a conservative estimate. The margin is likely much larger than that.

Finally, under the PPACA, any savings beyond what it costs to run the BHP must be plowed back into the program to improve it by expanding benefits or increasing provider rates. Given the concerns with provider access under Medicaid in part due to low reimbursement rates for some categories of providers, it will be important to prioritize provider rates with any excess savings. However, even if provider rates in the BHP are not increased over Medicaid rates (which, under the PPACA, must be increased to Medicare rates during 2013-2014 for primary care), the BHP population will be better served with a BHP with affordable care than through an unaffordable plan obtainable only through a risk-based Exchange insurer. According to Mercer, **50%** of the same population would forego participation in the Exchange due to this unaffordability (page 192), meaning that, for half of the population, the provider reimbursements would not be low; they would be non-existent.

In sum, the BHP option is a far better means than enrollment in a benchmark plan in the health insurance exchange for reducing the rolls of the uninsured, and at no additional cost to the state. Since HB 5485 would prevent this option from moving forward, and deprive the state of the ability to implement a plan that will efficiently provide quality, affordable care for all non-elderly individuals up to 200% of the poverty level, through a unitary seamless system, it should be rejected.

Thank you for considering my testimony.